

LETTERS TO THE EDITOR

Alternative and complementary medicine for asthma

Readers of the review by D J Lane and T V Lane (November 1991;46:787-97) might conclude that hypnosis has little to offer asthmatic patients. Although the report of Ewer and Stewart¹ is quoted as showing improvement in symptom scores and some peak expiratory flow rates and decreased use of bronchodilators, no mention is made of a 74.9% improvement ($p < 0.01$) in the degree of bronchial hyperresponsiveness to a standardised methacholine challenge test. These authors state that "while our hypnotic technique does not eliminate bronchial hyperresponsiveness it does provide a clinically useful and non-toxic adjuvant to drug treatment that might benefit about half of the asthmatic population." This approach could well reduce the use of the toxic drugs, such as troleandomycin, gold, azathioprine, and methotrexate, mentioned as steroid sparing agents by Shiner and Geddes.²

The British Tuberculosis Association's study³ did not report negative results as stated in the review. On the contrary, "independent clinical assessors considered the asthma to be much better in 59% of the hypnosis groups and in 43% of the control group, the difference being significant." These results were obtained by using only direct suggestion under hypnosis plus autohypnosis daily; more advanced methods, such as reciprocal inhibition, were not used.

In my own study⁴ it was possible to withdraw oral prednisolone or to reduce the dose in 14 of the 16 patients treated by hypnosis. The number of hospital admissions during the first year of hypnotherapy fell to 13, compared with 44 during the previous year. This represented a reduction of 249 hospital days, which, at 1988 costs (£170 per day), saved the NHS £42 330. As some 55 000 adults are admitted each year for asthma, savings to the NHS could be considerable if hypnotherapy were to be used more widely.

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- 1 Ewer TC, Stewart DE. Improvement in bronchial hyperresponsiveness in patients with moderate asthma after treatment with a hypnotic technique: a randomised controlled trial. *BMJ* 1986;293:1129-32.
- 2 Shiner RJ, Geddes JM. Treating patients with asthma who are dependent on systemic steroids. *BMJ* 1989;299:216-7.
- 3 British Tuberculosis Association. Hypnosis for asthma—a controlled trial. A report to the Research Committee of the British Tuberculosis Association. *BMJ* 1968;iv:71-6.
- 4 Morrison JB. Chronic asthma and improvement with relaxation induced by hypnotherapy. *J R Soc Med* 1988;81:701-4.

AUTHOR'S REPLY We thank Dr Morrison for his interest in our article. On the question of bronchial hyperresponsiveness, he seems to have missed our discussion of this on page 794. The changes recorded by Ewer and Stewart, though significant statistically, are unlikely to make much difference clinically. We know of no work on the use of hypnosis in

the sort of chronic persistent asthma that might be treated with the "toxic drugs" he mentions.

Perhaps we were unfair to dismiss the British Tuberculosis Association's study of 1968 as producing "negative results." In fact, the details of the recorded wheezing score, use of bronchodilators, and forced expiratory volume, divided by sex (their table IV), showed a difference between treated and control groups only for wheezing score in females (that is, five out of six comparisons showed no difference). The paper gives no details of the methods used for the independent clinical assessments other than that they "were made by a physician unaware of the patient's treatment."

Dr Morrison's own study gave impressive results, but it is a pity that the comparative control period had to be retrospective. Careful attention to many aspects of the care of asthmatic patients can produce a reduction in corticosteroid treatment and admissions. As we stated in our review, if hypnosis is to be advocated as a means of obtaining these ends there is a need to establish both a reliable method of screening for those likely to be susceptible to hypnosis and a standardised form of treatment acceptable to patients over long periods.

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We read the editorial entitled "Alternative and complementary medicine for asthma" by Dr DJ Lane and TV Lane (November 1991; 46:787-97) with great interest. Patients suffering from asthma often demand complete relief of their symptoms and therefore are not fully satisfied with present medications, which although highly effective are not curative. We have also observed an interest in alternative medicine among asthmatic patients in Turkey. We summarise the findings of an investigation both on the attitude towards "alternative" treatment and on the previous therapy practices of asthmatic patients who presented to the outpatient clinic of the department of chest diseases, Hacettepe University School of Medicine, Ankara, during 1991.

Of the 205 patients who were included in this study, 92 (45%) reported that they had either tried or were still using one or more of the alternative therapies recommended for asthma. Herbal medicine (48), speleotherapy (treatment based on visiting caves: 10), wearing bracelets (6), Turkish baths (5), rabies vaccine (3), and syrups containing various trace elements (3) had been used by these patients. Acupuncture was practised by only two patients; and other methods, such as yoga, hypnosis, and homeopathy, were not used by any.

We have collected 33 different prescriptions for herbal medicine from 48 patients. Numerous types of plants, leaves of trees, fruits, plant roots, and spices have been used either alone or in combination, usually mixed with honey. Though their benefit to the patient is questionable, they are regarded as harmless except for one containing oleander. Quail eggs, the only animal derived protein in these prescriptions, had been used by almost half of the patients.

Speleotherapy, the second most commonly used method, is used not only in Turkey but also in centres in Hungary, Poland, Czechoslovakia, Switzerland, and Italy.

Though there have been international meetings and an increasing number of articles on speleotherapy, there have been no controlled studies.¹⁻⁴ Some articles have discussed the temperature, humidity, volume, electrical characteristics, types of air flow, and gas content of the indoor environment, but no objective benefit of speleotherapy has been documented.^{5,6} Ten patients in our study group visited Damlatas cave in the south of Turkey for three to four weeks in the summer, and all stated that they had felt comfortable for several months after speleotherapy, being able to decrease their bronchodilator drug dosage. Further controlled and objective studies are needed on this subject.

Bracelets and Turkish baths are two methods of alternative medicine that have not previously mentioned in published reports. The "bracelet" epidemic spread from south east Asia to Turkey, and asthmatic patients as well as those with rheumatological problems began using bracelets. Six patients in the study group were wearing bracelets for the relief of their pulmonary symptoms.

Alternative medicine has emerged as a consequence of continuing efforts for more effective treatment for breathlessness. Some practices have arisen through experience that has accumulated over hundreds of years and have become traditional. Others have resulted from individual trials. We hope that public interest in alternative medicine will diminish in time with both progress in research for more efficient treatments and the realisation by patients of the effectiveness of conventional treatment.

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- 1 Skulimowski M. Behandlung der Bronchialasthmakranken in den Kammern der Steinsalzgrube in Wieliczka. *Arch Phys Ther* 1965; 17:417-21.
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- 3 Paskiva S, Kolesar J, Siposova E. Lungenautoantikörper bei Patienten mit Asthma bronchiale, die einer Speleo und Klimatherapie in Bystra unterworfen wurden. *Allerg Immunol* 1976;22:23-7.
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- 5 Kessler H, Morik J, Morlin Z, Varkonyi T. Air hygienic investigations in the lake of Tapolca. *Geographical Medicine* 1969-70;1:171-91.
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Air pollution and respiratory morbidity

We read with interest the article by Dr J Britton (May 1992;47:391-2). This raises a number of important points but perpetuates confusion over EC limit values, EC guide values, and WHO air quality guidelines; this confusion is present also in the paper of Sunyer *et al*¹ to which Dr Britton refers.

EC limit values and guide values are often expressed in terms of percentiles, with which individual measurements should not be compared. For example, the EC limit value for